Proposed Modifications for the January 1, 2020 Renewals of the State's Section 1915(c) Home and Community Based Services (HCBS): the Comprehensive Aggregate Cap Waiver & Statewide Waiver
and
the Self-Determination Waiver Amendment

Proposed Changes Applicable to the Comprehensive Aggregate Cap Waiver, Statewide Waiver, and Self-Determination Waiver

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. *Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

~~**a.i.c.1. # and % of newly employed (or reassigned) direct support staff delivering services to waiver participants who completed required training prior to direct service delivery. Percentage = # of newly employed (or reassigned) direct support staff who completed required training / total number of newly employed (or reassigned) direct support staff serving waiver participants in the QP sample.**~~

QP a.i.c.1. # and % of required trainings newly employed (or reassigned) direct support staff delivering services to waiver participants have completed prior to direct service delivery. Percentage = # of required trainings newly employed (or reassigned) direct support staff delivering services to waiver participants have completed prior to direct service delivery / total number of required trainings each newly employed (or reassigned) direct support staff are required to take prior to direct service delivery.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Non-Residential Homebound Support Services

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A person supported who is receiving a residential service (i.e., Supported Living, Residential Habilitation, Medical Residential Services, or Family Model Residential Support) shall not be eligible to receive the Non-Residential Homebound Support Service. A person receiving Semi-Independent Living Services shall not be eligible to receive the Non-Residential Homebound Support Service.

The Non-Residential Homebound Support Service shall not be provided during the same time period that the person supported is receiving, Personal Assistance, other Day Services, Respite Services, services under a 504 Plan or Individual Education Program (IEP), is being

homeschooled, or any combination thereof or as a substitute for education services which are available pursuant to IDEA, but which the person or his representative has elected to forego.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). The Non-Residential Homebound Support Service shall not be provided in a licensed facility (e.g., a group home, boarding home, or assisted living home).

The Non-Residential Homebound Support Service shall be limited to a maximum of 10 days in a 14 day billing period The Non-Residential Homebound Support Service shall be limited to a maximum of 10 days in a 14 day billing, ~~and excludes the first four (4) days in the billing period that a person meets the definition of 'homebound'~~.

The service cannot be billed until the homebound requirement is met—unable to participate in any employment or day service OR to leave the home except for medical treatment or medical appointments and for at no more than 2 hours a day for at least 5 days in the billing period.

The service cannot be billed on any day when any other employment or day service is provided.

Each day will be treated as twenty-four (24) quarter hour units for the purposes of including this service in the two-hundred forty (240) quarter-hour units cap on combined employment and day services in each 14-day billing period. The Non-Residential Homebound Support Service shall be limited to a maximum of 243 days per person per calendar year. Each day will be treated as twenty-four (24) quarter hour units for the purposes of including this service in the five-thousand eight-hundred thirty-two (5,832) quarter-hour units cap on combined employment and day services per year.

The Non-Residential Homebound Support Service may not be self-directed.

Supported Employment-Individual Employment Support

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- The Waiver will not cover SE-IES services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). If one or more of these services are authorized, documentation is maintained that the service is not available to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- Supported Employment-Individual Employment Supports shall not be provided during the same time period that the person is receiving Personal Assistance Services, Respite Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof, or as a substitute for education services which are available pursuant to the Individual with Disabilities Education Act (IDEA), but which the person or

his/her legal representative has elected to forego. Except for students who have graduated prior to May of 2014, employment and day services for school aged persons (i.e., under the age of 22) are limited to regular school break periods.

- These services are *only* for individuals seeking or engaged in individualized integrated employment or self-employment. These services are not for group employment of any size or variation.
- Job Coaching services do not include supports for volunteering or any form of unpaid internship, work experience or employment.
- Job Coaching shall not be provided in excess of actual need and cannot be billed for more hours than the individual, engaged in employment or self-employment, has worked in a billing period.
- These services do not include supporting paid employment or training in a sheltered workshop or similar facility-based setting.
- These services do not include supporting paid employment or training in a business enterprise owned or operated by a provider of these services. ~~Tennessee Department of Transportation rest areas, operated by a provider as part of State Use Program, where individuals employed are earning at least minimum wage and not working in a group, are excluded from this requirement.~~ Contracts operated by a provider as part of a State Use Program are prohibited; however, those individuals who are currently employed through a State Use Program may continue employment until the contract expires or the person loses the employment for any other reason, at which point, employment through any State Use Program is not an option.
- These services do not include payment for supervisory activities rendered as a normal part of the business setting and supports otherwise available to employees without disabilities filling the same or similar positions in the business.
- Exploration: After an individual has received the service for the first time, re-authorization may occur a maximum of once per year (with a minimum 365-day interval between services) and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment.
- Discovery: After an individual has received the service for the first time, re-authorization may occur a maximum of once every three years (with a minimum of three 365-day intervals between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within twelve (12) months.
- Job Development including Self-Employment Start-Up: After an individual has received the service for the first time, re-authorization may occur a maximum of once per year (with a minimum 365-day interval between services), and only if the person, at the time of re-authorization, is not already engaged in individualized integrated employment or self-employment, or other services to obtain such employment, and the person has a goal to obtain individualized integrated employment or self-employment within nine (9) months.
- Self-Employment Start-up: Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.
- Non-residential habilitation services (Supported Employment-Individual Employment Supports (except as noted below); Supported Employment-Small Group Employment Supports; Community Participation Supports; Intermittent Employment and Community Integration Wrap-Around Supports; Facility-Based Day Supports) and either the Residential Special Needs Adjustment-Homebound or the Non-Residential Homebound Support Service, when combined, may involve no more than 5,832 quarter hour units/year and no more than

240 quarter hour units in a fourteen day billing period. The Residential Special Needs Adjustment-Homebound and the Non-Residential Homebound Support Service are paid on a per diem basis and each day shall be considered as 24 quarter hour units for the purposes of including this service in the annual and billing period limits. Under Supported Employment-Individual Employment Supports, authorizations of Exploration, Discovery and Job Development are not included in these limits.

- These services will not duplicate other services provided through the Waiver or the Medicaid State Plan.
- Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
  - Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
  - Payments that are passed through to users of supported employment services; or
  - Payments for training that is not directly related to an individual's supported employment program.

Intermittent Employment and Community Integration Wrap-Around Supports

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Non-residential habilitation services (Supported Employment-Individual Employment Supports (except as noted below); Supported Employment-Small Group Employment Supports; Community Participation Supports; Intermittent Employment and Community Integration Wrap-Around Supports; Facility-Based Day Supports) and either the Residential Special Needs Adjustment-Homebound or the Non-Residential Homebound Support Service, when combined, may involve no more than 5,832 quarter hour units/year and no more than 240 quarter hour units in a fourteen day billing period. The Residential Special Needs Adjustment-Homebound and the Non-Residential Homebound Support Service are paid on a per diem basis and each day shall be considered as 24 quarter hour units for the purposes of including this service in the annual and billing period limits. Under Supported Employment-Individual Employment Supports, authorizations of Exploration, Discovery and Job Development are not included in these limits.
- In authorizing Intermittent Employment and Community Integration Wrap-Around Supports, units authorized shall be counted for the purposes of implementing the overall annual and billing period limit in (1.) above but Intermittent Employment and Community Integration Wrap-Around Supports shall be limited to no more than 160 quarter hour units in a 14 day billing period and no more than 3,888 quarter hour units/year limit. A waiver participant may receive this service up to four (4) hours on same day that at least two (2) hours of Supported Employment (Individual and/or Small Group) and/or Community Participation Supports are also provided (or the waiver participants spends at least two (2) hours working in the community and/or participating in the community without staff support because the staff support is not necessary). The two (2) hours of Supported Employment (Individual and/or Small Group) and/or Community Participation Supports (or the two hours the waiver participant spends working in the community and/or participating in the community without staff support because the staff support is not necessary) may or may not be consecutive hours. On a given day, home-based supports that are needed in excess of four (4) hours are considered to be the responsibility of the residential provider. In the case of a waiver participant that lives with the family, this is considered to be the responsibility of the family or

covered by Personal Assistance authorization. Further, the amount of units authorized shall in all cases be limited based on documented needs of the individual and shall not be authorized for the purposes of supplementing other non-residential habilitation services up to the maximum hours of service allowable if there is not a documented need for this amount of service. These supports are designed to address intermittent needs which will vary by individual waiver participant.

- Intermittent Employment and Community Integration Wrap-Around Supports shall not be provided during the same time period that the person is receiving Personal Assistance Services, Respite Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof, or as a substitute for education services which are available pursuant to the Individual with Disabilities Education Act (IDEA), but which the person or his/her legal representative has elected to forego. Except for students who have graduated prior to May of 2014, Day Services for school aged persons (i.e., under the age of 22) are limited to regular school break periods.
- The Intermittent Employment and Community Integration Wrap-Around Support service may not be provided on the same date as Facility-Based Day Supports.
- The Intermittent Employment and Community Integration Wrap-Around Support service may not be provided on the same date as Facility-Based Day Supports.

Facility-Based Day Supports

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Non-residential habilitation services (Supported Employment-Individual Employment Supports (except as noted below); Supported Employment-Small Group Employment Supports; Community Participation Supports; Intermittent Employment and Community Integration Wrap-Around Supports; Facility-Based Day Supports) and either the Residential Special Needs Adjustment-Homebound or the Non-Residential Homebound Support Service, when combined, may involve no more than 5,832 quarter hour units/year and no more than 240 quarter hour units in a fourteen day billing period. The Residential Special Needs Adjustment-Homebound and the Non-Residential Homebound Support Service are paid on a per diem basis and each day shall be considered as 24 quarter hour units for the purposes of including this service in the annual and billing period limits. Under Supported Employment-Individual Employment Supports, authorizations of Exploration, Discovery and Job Development are not included in these limits.
- Facility-Based Day Supports may only be authorized for up to six (6) months at one time. Before any and every reauthorization, a review must occur to determine whether the facility remains the most integrated setting where the person's goals and needs can be effectively met, whether there are opportunities for the person to transition into more integrated settings and services, including supported employment and community participation, and whether – if time-limited prevocational services are being provided – there are opportunities to provide these services in an integrated, community-based setting(s) where learning is likely to be more directly transferable to, and applicable for, participation in competitive integrated employment, including supported employment.

- Facility-Based Day Services shall not be provided during the same time period that the person is receiving Personal Assistance Services, Respite Services, or services under a 504 Plan or Individual Education Program (IEP), is being homeschooled, or any combination thereof, or as a substitute for education services which are available pursuant to the Individual with Disabilities Education Act (IDEA), but which the person or his/her legal representative has elected to forego. Except for students who have graduated prior to May of 2014, Day Services for school aged persons (i.e., under the age of 22) are limited to regular school break periods.
- Facility-Based Day Supports may not be provided on the same date as the Intermittent Employment and Community Integration Wrap-Around Support service.
- Facility-Based Day Supports shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).
- Facility-Based Day Supports exclude services available to an individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).
- Paid work done as part of Facility-Based Day Supports must be compensated consistent with applicable state and federal labor laws and must provide the opportunity for participants to earn wage increases over time.
- Facility-Based Day Supports does not include vocational services or the provision of employment opportunities solely intended to provide long-term employment and earned income to participants.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field described the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complied with federal HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; The settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB Settings in the waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Character Count=60,000

Completed.

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Services are provided in a person's home and community. Specific setting types include residential and non-residential. All settings in which HCBS are provided, and not otherwise included in the HCB Settings Transition Plan for this waiver, comport with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes. Exceptions to these requirements are made only when supported by the individual's specific assessed need and specified in the person-centered ISP.

All individual goals and objectives, along with needed supports to progress toward, achieve or sustain these goals and objectives, are established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the person supported. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

The Interagency Agreement between TennCare and DIDD for operation of these waivers includes HCBS Settings Rule compliance, as do Provider Agreements with providers, TennCare, and DIDD. In addition, HCBS Settings Rule language has been added to the DIDD Provider Manual that sets requirements related to individual rights and modifications to the Rule. Each provider is assessed at a minimum, at enrollment, and during the quality assurance survey process to ensure that each service is being delivered to all persons supported in a manner that comports with federal waiver assurances, and the HCBS settings rule.

Compliance at the individual member level will continue to be assessed through oversight of the person-centered planning process and review of member experience data. An assessment of each person's experience is embedded into the person-centered planning process on an ongoing basis to ensure that services and supports received by that person are non-institutional in nature, and consistent with the requirements and objectives of the HCBS settings rule. This is conducted by the Independent Support Coordinator, or Case Manager, as applicable, as part of the person's annual person-centered plan review. This assessment is intended to measure each individual's level of awareness of and access to rights provided in the HCBS Settings Rule, freedom to make informed decisions, community integration, privacy requirements, and other individual experience expectations as outlined in the HCBS Settings Rule. DIDD reviews assessment responses for all Medicaid recipients receiving services in this waiver and investigates each "No" response that indicates a potential area of non-compliance or potential rights restriction to determine if the provider is in compliance with the HCBS Settings Rule, and with respect to restrictions, to ensure the restriction has gone through the HCBS Settings Rule modifications procedure, and is appropriately included in the person-centered support plan. If the restriction has not gone through the modification process and is not supported in the person-centered support plan, DIDD remediates the concern by working with the provider and the person supported and his or her representative, if applicable.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The state, on an*

ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

a. *Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.* *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance measure H.W.a.i.24 will be deleted and replaced with H.W.a.i.25

~~**H.W.a.i.24:Number and percentage of DIDD providers who deliver services in accordance with the DIDD Provider Manual and policies related to health care management and oversight. Numerator = Number and percentage of DIDD providers who deliver services in accordance with the DIDD Provider Manual and policies related to health care management and oversight. Denominator = Total number of providers surveyed during the month.**~~

HWa.i.25 Number and percentage of people whose emerging health problems or issues are being addressed by provider staff. Numerator = Number of people whose emerging health problems or issues are being addressed by provider staff. Denominator= Total # of persons supported in the sample during the month.

The following Performance Measures will be deleted:

~~**H.W.a.i.13. Number and percentage of deaths of reviewed and determined to be of unexplained or suspicious cause. Percentage = number of deaths of unexplained or suspicious cause / total number of deaths.**~~

~~**H.Wa.i.9. Number and percentage of completed DIDD investigations for which abuse, neglect, and/or exploitation was substantiated, by type. Percentage = number of substantiated allegations, by type / number of investigations, by type.**~~

Performance Measures a.i.8, a.i.9, a.i.13 and a.i.23: Data describing reportable critical incidents and investigations is entered on an ongoing basis into the DIDD Incident and Investigation Database. Monthly reports are generated that include data describing critical incidents reported and investigations initiated/completed during the month. This data will be compiled by designated DIDD staff and analyzed and trended monthly, year-to-date, and annually by DIDD Regional and State Quality Management Committees. DIDD also performs death reviews. Waiver service providers are required to report any death that is or may be a Suspicious, Unexpected, or Unexplained Death within four hours of discovery to designated DIDD Regional Office staff who record the circumstances of the death. Within one business day of the date of the death, a Notice of Death form must be completed by the waiver service provider and submitted to the DIDD Regional Director. Upon receipt of a Notice of Death form, the DIDD Regional Director or designee schedules a Preliminary Death Review Committee meeting. Within five business days of receipt of the Notice of Death, the Preliminary Death Review Committee shall perform a preliminary death review to determine if the death was Suspicious, Unexpected, or Unexplained. Any death determined to be Suspicious, Unexpected, or Unexplained shall trigger a DIDD Investigation, the preparation of a Clinical Death Summary, and a DIDD Death Review. The purpose of a DIDD Death Review is to conduct a comprehensive analysis of the relevant facts and circumstances, including the medical care provided, to identify practices or conditions which may have contributed to the death and to make recommendations, where necessary, to prevent similar occurrences. Although performance measures a.i.9 and a.i.13 will no longer be reported with the 2020 Renewal, as requested by CMS in the Final Quality Reports, the state will continue using the strategies outlined above to collect, track, and analyze monthly data related to deaths and substantiated investigations.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. *Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.* *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

~~**F.A.a.i.1 Number and percentage of claims denied or suspended for incorrect billing codes or service rates. Percentage = number of claims denied or suspended / total number of claims submitted.**~~

F.A.a.i.1. Number and percentage of claims correctly billed with correct billing codes and service rates. Numerator: Percentage = number of claims correctly billed with correct billing codes and service rates / total number of claims submitted.

Proposed Changes Applicable Only to the Comprehensive Aggregate Cap Waiver and the Statewide Waiver

Residential Habilitation

Service Definition (Scope):

Character Count = 12,000

Residential Habilitation shall mean a type of residential service selected by the person supported, offering individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside in a community-based setting and which supports each resident's independence and full integration into the community, and ensures each resident's choice and rights. Residential Habilitation services shall be provided in a dwelling which may be rented, leased, or owned by the Residential Habilitation provider, and shall comport fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the person supported. Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation, household chores) essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices. Residential Habilitation may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Residential Habilitation provider shall oversee the person's health care needs.

The Residential Habilitation dwelling shall be licensed by the State of Tennessee.

A Residential Habilitation home shall have no more than 4 residents with the exception that homes which were already providing services to more than 4 residents prior to July 1, 2000, may continue to do so.

Individuals receiving Residential Habilitation services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted pursuant to state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.

The Residential Habilitation provider shall be responsible for providing an appropriate level of services and supports for up to 24 hours per day during the hours the person supported is not receiving Day Services or is not at school or work,- based on the person's support needs. Persons supported should receive the amount of support they need while also, consistent with the federal HCBS Settings Rule, have freedom in choosing to spend time alone or engage in activities without paid staff present, unless there are specific safety concerns that cannot be mitigated to a tolerable level of risk. Providers are responsible for providing an appropriate level of supports, including enabling technology, paid staff, and natural supports, as applicable, to ensure each person's health and safety, while maximizing personal choice and independence,

and not restricting individual rights and freedoms, except as minimally necessary and in accordance with the federal Rule.

A person supported who is receiving Residential Habilitation shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the Residential Habilitation provider).

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program, and in accordance with TennCare protocol, transportation shall be a component of Residential Habilitation and shall be included in the reimbursement rate for such.

Reimbursement for Residential Habilitation shall not be made for room and board or for the cost of maintenance of the dwelling. Reimbursement for Residential Habilitation shall not include payment for Residential Habilitation provided by the spouse of a person supported. The Residential Habilitation provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Residential Habilitation provided by such individuals. Reimbursement for Residential Habilitation shall not include payment made for services provided by an individual who has been appointed as the conservator of the person supported, unless so permitted in the Order for Conservatorship.

This service shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Residential Habilitation shall not be provided in a home where a person supported lives with family members unless such family members are also persons supported. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.

Residential Habilitation may be provided out-of-state under the following circumstances:

a. Out-of-state services shall be limited to a maximum of 14 days per person supported per waiver program year (i.e. calendar year).

b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).

c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.

d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

The Residential Special Needs Adjustment – Homebound (RSNA-HB) is a supplementary per diem payment that may be approved in limited circumstances as specified herein for Residential Habilitation services that are provided in the individual's residence when the individual is determined by TennCare and DIDD to meet the definition of 'homebound" and as a result, is unable (not unwilling) to participate in any employment or day service and must remain at their residence for the full 24 hours of a particular day, except leaving the home for medical treatment or medical appointments, and requires paid support in the residence during that time. 'Homebound' is defined as being unable (not unwilling) to leave your home except for medical

treatment or medical appointments and unable to participate in any employment or day service for at least 2 hours per day (the 2 hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14 day billing period.
RSNA-HB can only be authorized and paid in limited exceptional circumstances when engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to:
1. Needs related to end of life. End-of-life issues relate to someone's death and the time just before it, when it is known that they are likely to die soon from a terminal illness or similar condition. The person is receiving support and medical care given during the time surrounding death.
2. Needs related to a sustained behavioral crisis, involving behaviors not otherwise typical for the individual. These behaviors are not considered safe and/or would be sufficiently disruptive if displayed in the community and/or at a place of employment so as to cause issues that would interfere with successful participation in the community and or in community employment.
3. Needs related to recovery after a period of hospitalization, recovery due to being admitted to hospital ICU, emergency illness, surgical complication or accident.
4.Significantly health compromised - A chronic health issue, supported by current medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise the individual's health and physical well-being.

RSNA-HB payments are intended to be as time-limited as possible, with a goal of supporting the individual to engage in employment or other integrated community activities and must be reviewed and reauthorized, as appropriate, at a minimum, every 90 days, and not on a continuous basis, except in exceptional circumstances as approved by TennCare and DIDD (e.g., end of life). All individual goals and objectives, and specific needed supports, related to authorization of the RSNA- HB, and to supporting the individual's ability to participate in employment and other integrated community activities shall be established through the person-centered planning process and documented in the person-centered ISP.
The RSNA-HB can only be authorized and paid for services provided on the same day that Residential Habilitation services are also authorized and provided.

Family Model Residential

Service Definition (Scope):

Family Model Residential Support shall mean a type of residential service selected by the person supported, where he or she lives in the home of a trained caregiver who is a not family member in an "adult foster care" arrangement. A family member(s) of the persons supported shall not be reimbursed to provide Family Model Residential Support services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.
In this type of shared living arrangement, the caregiver allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and family, supports each resident's independence and full integration into the community, ensures each resident's

choice and rights, and supports each resident in a manner that comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual. Family Model Residential Support includes individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside successfully in a community-based setting, living in a family environment in the home of trained caregivers other than the family of origin. Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation excluding cost of food), household chores essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

Family Model Residential Supports may include medication administration as permitted under Tennessee's Nurse Practice Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Family Model Residential Support caregiver shall oversee the health care needs of the person supported.

The Family Model Residential Support provider agency shall not find, purchase, or lease a residence in which Family Model Residential Supports will be provided. Family Model Residential Support caregivers shall be recruited, screened, contracted, and trained prior to providing services, and monitored by the Family Model Residential Support provider agency to ensure compliance with licensing and program requirements. The Family Model Residential Support provider agency shall facilitate matching of persons supported and caregivers but shall not determine whether a caregiver chooses to participate in the program, whether a caregiver will bring a particular person supported into his or her home, or how the day-to-day activities of the home and provision of services and supports will occur. Visits, both announced and unannounced, and phone calls to the home must occur on a regular basis in order for the provider agency to ensure compliance with program requirements and the general health and safety of the person supported, but should not be so prescriptive as to instruct the provider about particular tasks to perform or ways to fulfill or not fulfill duties. Family Model Support caregivers are responsible for abiding by the quality assurance standards, outlined in the DIDD Provider Manual, which are monitored and enforced by DIDD.

A Family Model Residential Support home shall have no more than 3 residents who receive services and supports regardless of HCBS program or funding source.

The Family Model Residential Support provider shall be responsible for providing an appropriate level of services and supports for up to 24 hours per day during the hours the person supported is not receiving Day Services or is not at school or work, ~~or~~ based on the person's support needs. Persons supported should receive the amount of support they need while also, consistent with the federal HCBS Settings Rule, have freedom in choosing to spend time alone or engage in activities without paid staff present, unless there are specific safety concerns that cannot be mitigated to a tolerable level of risk. Providers are responsible for providing an appropriate level of supports, including enabling technology, paid staff, and natural supports, as applicable, to ensure each person's health and safety, while maximizing personal choice and independence, and not restricting individual rights and freedoms,

except as minimally necessary and in accordance with the federal Rule.

With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Family Model Residential Support and shall be included in the reimbursement rate for such.
Family Model Residential Support shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).
Reimbursement for Family Model Residential Support shall not include payment for Family Model Residential Support provided by the spouse of a person supported. The Family Model Residential Support provider and provider staff shall not be the parent or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Family Model Residential Support provided by such individuals. Reimbursement for Family Model Residential Support shall not include payment made to any other individual who is a conservator, unless so permitted in the Order for Conservatorship.
Reimbursement for Family Model Residential Support shall not be made for room and board or for the cost of maintenance of the dwelling.
Family Model Residential Support may be provided out-of-state under the following circumstances,:
a. Out-of-state services shall be limited to a maximum of 14 days per person supported per calendar year.
b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).
c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.
d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.
The Residential Special Needs Adjustment – Homebound (RSNA-HB) is a supplementary per diem payment that may be approved in limited circumstances as specified herein for Family Model Residential Support service that are provided in the individual's residence when the individual is determined by TennCare and DIDD to meet the definition of 'homebound" and as a result, is unable (not unwilling) to participate in any employment or day service and must remain at their residence for the full 24 hours of a particular day, except leaving the home for medical treatment or medical appointments, and requires paid support in the residence during that time. 'Homebound' is defined as being unable (not unwilling) to leave your home except for medical treatment or medical appointments and unable to participate in any employment or day service for at least 2 hours per day (the 2 hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14 day billing period.
RSNA-HB can only be authorized and paid in limited exceptional circumstances when engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to:
1. Needs related to end of life. End-of-life issues relate to someone's death and the time just before it, when it is known that they are likely to die soon from a terminal illness or similar condition. The person is receiving support and medical care given during the time surrounding death.

2. Needs related to a sustained behavioral crisis, involving behaviors not otherwise typical for the individual. These behaviors are not considered safe and/or would be sufficiently disruptive if displayed in the community and/or at a place of employment so as to cause issues that would interfere with successful participation in the community and or in community employment.
3. Needs related to recovery after a period of hospitalization, recovery due to being admitted to hospital ICU, emergency illness, surgical complication or accident.
4.Significantly health compromised - A chronic health issue, supported by current medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise the individual's health and physical well-being.

RSNA-HB payments are intended to be as time-limited as possible, with a goal of supporting the individual to engage in employment or other integrated community activities and must be reviewed and reauthorized, as appropriate, at a minimum, every 90 days, and not on a continuous basis, except in exceptional circumstances as approved by TennCare and DIDD (e.g., end of life). All individual goals and objectives, and specific needed supports, related to authorization of the RSNA- HB, and to supporting the individual's ability to participate in employment and other integrated community activities shall be established through the person-centered planning process and documented in the person-centered ISP.
The RSNA-HB can only be authorized and paid for services provided on the same day that Family Model Residential Support service is also authorized and provided.

Supported Living

Service Definition (Scope):

Supported Living shall mean a type of residential service selected by the person supported having individualized services and supports that enable the person supported to acquire, retain, or improve skills necessary to reside in a home that is owned or leased by the residents and which supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP. All individual goals and objectives, along with needed supports shall be established through the person-centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual. Supports may include direct assistance as needed with, participating in, and learning how to complete independently activities of daily living (e.g., bathing, dressing, personal hygiene, eating, meal preparation (excluding cost of food), household chores essential to the health and safety of the person supported, budget management (which shall include supporting the individual in managing his/her personal funds, as appropriate), attending appointments, and interpersonal and social skills building to enable the person supported to live in a home in the community. Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.
Supported Living may include medication administration as permitted under Tennessee's Nurse Practice

Act and performance of other non-complex health maintenance tasks, as permitted by State law. The Supported Living provider shall oversee the health care needs of the person supported.
The Supported Living provider shall not own the place of residence of the person supported or be a co-signer of a lease on the place of residence of the person supported unless the Supported Living provider signs a written agreement with the person supported that states that the person supported will not be required to move if the primary reason is because the person supported desires to change to a different Supported Living provider. A Supported Living provider shall not own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person supported if such entity requires, as a condition of renting or leasing, the person supported to move if the Supported Living provider changes.
The person supported (or the parent, guardian, or conservator acting on behalf of the person supported) shall have a voice in choosing the individuals who reside in the Supported Living residence and the staff who provide services and supports.
A Supported Living home shall have no more than 3 residents including the person supported. Unless the residence is individually licensed or inspected by a public housing agency utilizing the HUD Section 8 safety checklist, the residence must pass a home inspection approved by the State Medicaid Agency.
The Supported Living provider shall be responsible for providing an appropriate level of services and supports up to 24 hours per day during the hours the person supported is not receiving Day Services, is not otherwise engaged with natural supports, is not at school or work, ~~or~~ based on the person's support needs. Persons supported should receive the amount of support they need while also, consistent with the federal HCBS Settings Rule, have freedom in choosing to spend time alone or engage in activities without paid staff present, unless there are specific safety concerns that cannot be mitigated to a tolerable level of risk. Providers are responsible for providing an appropriate level of supports, including enabling technology, paid staff, and natural supports, as applicable, to ensure each person's health and safety, while maximizing personal choice and independence, and not restricting individual rights and freedoms, except as minimally necessary and in accordance with the federal Rule.
Thus, a person supported who is receiving Supported Living shall not be eligible to receive Personal Assistance or Respite (which would duplicate services that are the responsibility of the Supported Living provider).
Supported Living shall not be provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)). Supported Living shall not be provided in a home where a person supported lives with family members unless such family members also receive Supported Living services, or by special exception when the family member is a minor child living with a parent receiving services or spouse of a person receiving services. Family member shall be interpreted to mean the mother, father, grandmother, grandfather, sister, brother, son, daughter, or spouse, whether the relationship is by blood, by marriage, or by adoption.
In Supported Living companion model, family and friends of the companion staff may only reside in the home of the person supported when approved by the person supported or his/her conservator. Such approval shall be documented in the person-centered ISP. Individuals receiving Supported Living services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.
Supported Living shall not be covered for persons supported under age 18 years.
With the exception of transportation to and from medical services covered through the Medicaid State Plan/TennCare Program and in accordance with TennCare protocol, transportation shall be a component of Supported Living and shall be included in the reimbursement rate for such.
Reimbursement for Supported Living shall not include payment for Supported Living provided by the spouse of a person supported. The Supported Living provider and provider staff shall not be the parent

or custodial grandparent of a person supported under age 18 years, whether the relationship is by blood, by marriage, or by adoption; and reimbursement shall not include payment for Supported Living provided by such individuals.

Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the person supported and who provides services to the person supported in the home of the person supported. Reimbursement for Supported Living shall not include the cost of maintenance of the dwelling. Residential expenses (e.g., phone, cable TV, food, rent) shall be apportioned between the person supported, other residents in the home, and (as applicable) live-in or other caregivers. For Supported Living services in a companion model home, all U.S. Department of Labor, Wage and Hour Division rules shall be applied to live-in caregivers.

Supported Living may be provided out-of-state under the following circumstances:

a. Out-of-state services shall be limited to a maximum of 14 days per person supported per calendar year.

b. The waiver service provider agency must be able to assure the health and safety of the person supported during the period when services will be provided out-of-state and must be willing to assume the additional risk and liability of provision of services out-of-state (i.e., provision of out-of-state services is at the discretion of the service provider).

c. During the period when out-of-state services are being provided, the waiver service provider agency must maintain an adequate amount of staffing (including services of a nurse if applicable) to meet the needs of the person supported and must ensure that staff meet waiver provider qualifications.

d. The waiver service provider agency shall not receive any additional reimbursement for provision of services out-of-state. The costs of travel, lodging, food, and other expenses incurred by staff during the provision of out-of-state services shall not be reimbursed through the waiver. The costs of travel, lodging, food, and other expenses incurred by the person supported while receiving out-of-state services shall be the responsibility of the person supported and shall not be reimbursed through the waiver.

The Residential Special Needs Adjustment – Homebound (RSNA-HB) is a supplementary per diem payment that may be approved in limited circumstances as specified herein for Supported Living service that are provided in the individual's residence when the individual is determined by TennCare and DIDD to meet the definition of 'homebound" and as a result, is unable (not unwilling) to participate in any employment or day service and must remain at their residence for the full 24 hours of a particular day, except leaving the home for medical treatment or medical appointments, and requires paid support in the residence during that time. 'Homebound' is defined as being unable (not unwilling) to leave your home except for medical treatment or medical appointments and unable to participate in any employment or day service for at least 2 hours per day -(the 2 hours may or may not be consecutive) for a sustained period of time which is at least 5 days in a 14 day billing period.

RSNA-HB can only be authorized and paid in limited exceptional circumstances when engaging in integrated community participation and/or integrated community employment outside the home is not possible for the individual due to:

1. Needs related to end of life. End-of-life issues relate to someone's death and the time just before it, when it is known that they are likely to die soon from a terminal illness or similar condition. The person is receiving support and medical care given during the time surrounding death.

2. Needs related to a sustained behavioral crisis, involving behaviors not otherwise typical for the individual. These behaviors are not considered safe and/or would be sufficiently disruptive if displayed in the community and/or at a place of employment so as to cause issues that would interfere with successful participation in the community and or in community employment.

3. Needs related to recovery after a period of hospitalization, recovery due to being admitted to

hospital ICU, emergency illness, surgical complication or accident.
4.Significantly health compromised - A chronic health issue, supported by current medical records that restricts the person from leaving their home under certain pre-determined circumstances, including environmental issues i.e. extreme heat or cold, high pollen, air quality, exposure (geographically) to high incidences of communicable disease etc., that would further compromise the individual's health and physical well-being.

RSNA-HB payments are intended to be as time-limited as possible, with a goal of supporting the individual to engage in employment or other integrated community activities and must be reviewed and reauthorized, as appropriate, at a minimum, every 90 days, and not on a continuous basis, except in exceptional circumstances as approved by TennCare and DIDD (e.g., end of life). All individual goals and objectives, and specific needed supports, related to authorization of the RSNA- HB, and to supporting the individual's ability to participate in employment and other integrated community activities shall be established through the person-centered planning process and documented in the person-centered ISP.

The RSNA-HB can only be authorized and paid for services provided on the same day that Supported Living service is also authorized and provided.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Independent Support Coordinators (ISCs) assist persons supported in identifying their needs and preferences and selecting, obtaining and coordinating services using paid and natural supports. The ISC, in collaboration with the person supported, the person supported authorized representative (if applicable), other persons specified by the person supported (this may include family members, friends, and paid service providers selected by the person) convene at time and location convenient to the

person supported, in a formal Planning Meeting to discuss and finalize the ISP which is the person-centered ISP.

Each person-centered planning process must:

a. Be directed by the individual to the greatest extent possible,

b. Identify strengths and needs, both clinical and support needs, and desired outcomes,

c. Reflect cultural considerations and use language understandable by the individual

d. Include strategies for solving disagreements

e. Provide method for individual to request updates to be made to their ISP

The policy and procedures which define and guide the person-centered planning process and assure that people chosen by the individual supported are integrally involved in the development of an ISP that reflects their preferences, choices, and desired outcomes provide for:

a. An assessment of the individual's status, adaptive functioning, and service needs through the administration of a uniform assessment instrument (such as the Supports Intensity Scale);

b. The identification of individual risk factors through the administration of a ~~the~~ uniform risk assessment~~Risk Issues Identification Tool~~, ~~and~~ identification of person-centered strategies to mitigate risks, and clear communication with the person supported and/or his/her representative, as applicable, regarding potential risks and ways to mitigate risks to support an informed decision regarding whether the risk, as mitigated, is tolerable, including documentation of the person's decision in the ISP;~~including documentation of the individual's understanding of the risks and mitigation strategies, including documentation that those strategies have been clearly explained;~~

c. Additional assessments, where appropriate, by health care professionals (e.g., occupational or physical therapists, behavior analysts, etc.);

d. The identification of personal outcomes, support goals, supports and services needed, information about the person's current situation, what is important to the person supported, and changes desired in the person's life (e.g., home, work, relationships, community membership, health and wellness). (Information for the ISP will be gathered and developed through the person-centered planning process driven, to the greatest extent possible, by the person supported and, if applicable, in collaboration with the guardian or conservator, as well as family members and other persons specified by the person supported.);

e. At least annual assessment of the individual's experience to confirm that that the setting in which the individual is receiving services and supports comports with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP; and

f. Waiver and other services are coordinated by the ISC through the development and implementation of the ISP. The ISP describes all the supports and services necessary to support the person to achieve their desired outcomes and attain or maintain a quality life as defined by them,

including services that may be provided through natural supports, the Medicaid State Plan or pursuant to the person's Individual Education Plan (IEP).

The ISP development process includes the following: identification of personal outcomes, support goals, supports and services needed, information about the individual's current situation, what is important to the individual, and changes desired in the person's life (e.g., home, work, relationships, community membership, health and wellness), supporting the individual's informed choice regarding services and supports they receive, providers of such services, and the setting in which services and supports are received and which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS; and specific documentation of any modifications to HCBS settings requirements based on the needs of the individual and in accordance with processes prescribed in federal and state regulation and protocol. As required pursuant to the federal Personal Centered Planning Rule, the ISP shall be signed by the individual and all persons involved in implementing the plan, including those providing paid and or unpaid supports.

The ISP is the fundamental tool by which the state ensures the health and welfare of the individuals served under this waiver. As such, it is subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the person's disability and are responsive to the person's needs and preferences. Ongoing monitoring by the ISC is accomplished through a stratified approach, based on level of support need, as follows: A person assessed to have level of need 1, 2, or 3 for purposes of reimbursement or not receiving any residential or day service requires a minimum of at least one monthly in-person or telephone contact and at least one bi-monthly (every other month) face-to-face contact; at least one visit per quarter shall be conducted in the person's home. A person assessed to have level of need 4, 5, or 6 for purposes of reimbursement requires a minimum of at least one monthly face-to-face contact across all environments and in the person's residence at least quarterly. Each contact, whether in person or by phone, requires the ISC to complete and document a Monthly Status Review of the ISP for that person per service received across service settings. ~~through a stratified approach, based on level of support need, as follows: A person assessed to have level of need 1, 2, or 3 for purposes of reimbursement or not receiving any service reimbursed based on level of need requires a minimum of at least one monthly in-person or telephone contact and at least one bi-monthly (every other month) face-to-face contact in the person's home. A person assessed to have level of need 4, 5, or 6 for purposes of reimbursement requires a minimum of at least one monthly face-to-face contact across all environments and in the person's residence at least quarterly. Each contact, whether in person or by phone, requires the ISC to complete and document a Monthly Status Review of the ISP for that person per service received across service settings. monthly face-to-face monitoring visits.~~ Face-to-face visits should be coordinated with the person supported (and their family, as applicable) and should generally occur in the person's residence at least once per quarter. However, for persons not receiving residential services, if requested by the person (or their family, as applicable), visits can be scheduled at alternative locations that are convenient for the person and their family, unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted in the home. When an individual receives residential services, one face-to-face visit per quarter (i.e. once every 3 months) must take place in the individual's residence. Face-to-face and/or

telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request ~~which shall be documented in the ISP,~~ or based on a significant change in needs or circumstances. ~~Completion of a monthly status review of the ISP will be documented for each individual per service received and across service settings.~~

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Independent Support Coordinators (ISC) assist persons supported in identifying needs and preferences, and in selecting, obtaining, and coordinating services using paid and natural supports. Ongoing monitoring by ISCs is essential and they are responsible for determining if services are being implemented as specified in the ISP and if the services described in the plan are meeting the person's needs. ~~Ongoing monitoring by the ISC is accomplished through monthly face-to-face monitoring visits. Face-to-face visits should be coordinated with the person supported (and their family, as applicable) and should generally occur in the person's residence at least once per quarter. However, if requested by the person (or their family, as applicable), visits can be scheduled at alternative locations that are convenient for the person and their family, unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted in the home. When an individual receives residential services, one face-to-face visit per quarter (i.e. once every 3 months) must take place in the individual's residence. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request which shall be documented in the ISP, or based on a significant change in needs or circumstances. Completion of a monthly status review of the ISP will be documented for each individual per service received and across service settings.~~

Ongoing monitoring by ISCs is accomplished through a stratified approach, based on level of support need, as follows: A person assessed to have level of need 1, 2, or 3 for purposes of reimbursement or not receiving any residential or day service requires a minimum of at least one monthly in-person or telephone contact and at least one bi-monthly (every other month) face-to-face contact; at least one visit per quarter shall be conducted in the person's home. A person assessed to have level of need 4, 5, or 6 for purposes of reimbursement requires a minimum of at least one monthly face-to-face contact across all environments and in the person's residence at least quarterly. Each contact, whether in person or by phone, requires the ISC to complete and document a Monthly Status Review of the ISP for that person per service received across service settings. Generally, face-to-face visits should be coordinated with the person supported (and

their family, as applicable) to occur in the person's residence. However, for persons not receiving residential services, if requested by the person (or their family, as applicable), visits can be scheduled at alternative locations that are convenient for the person and their family, unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted in the home. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request ~~which shall be documented in the ISP~~, or based on a significant change in needs or circumstances. The frequency of monitoring visits shall be specified in the ISP and may be provided more frequently as needed.

Information is gathered using standardized processes and tools. The ISC reports issues identified to management staff from the appropriate provider agencies. DIDD Regional Office management staff may assist in achieving resolution when timely provider response does not occur. All individuals who receive supports and services through DIDD are required to have an annual risk assessment. This assessment is a component of the planning process intended to identify potential risks and create an environment that establishes appropriate safeguards without limiting personal experiences. Risk management is accomplished through risk assessment and identification of risk factors, risk analysis and planning, ongoing evaluation of the effectiveness of risk management strategies, and staff training and re-training as appropriate.

The success of individual strategies to ameliorate individual risks identified through risk assessment are evaluated by the person supported, their families and significant others, providers, and the ISC as part of on-going planning for and monitoring of services.

In addition, the ISC conducts initial (i.e., as part of the State's initial assessment of compliance with the new federal HCBS Setting rule) and at least annual assessment of the individual's experience, in accordance with timeframes outlined in State Protocol, to confirm that that the setting in which the person supported is receiving services and supports comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

ISC Visits /Support Coordination Definition

Support Coordination shall mean the assessment, planning, implementation, coordination, and monitoring of services and supports that assist individuals with intellectual and developmental disabilities to develop personal relationships, participate in their community, increase control over their own lives, and develop the skills and abilities needed to achieve these goals, person supported as specified in person supported the individual's person-centered Individual Support Plan (ISP). Support Coordination shall be provided in a manner that comports fully with standards applicable to person-centered planning for services delivered under Section 1915(c) of the Social Security Act.

Specific tasks performed by the Support Coordination provider shall include, but are not limited to general education about the waiver program, including individual rights and responsibilities; providing necessary information and support to the individual to support his/her direction of the person-centered planning process to the maximum extent desired and possible; initial and ongoing assessment of the individual's strengths and needs; identification of what is important to the individual, including preferences for the delivery of services and supports; actual development, ongoing evaluation, and updates to the ISP as needed or upon request of the individual; coordination with the individual's health care providers and MCO(s), as applicable, to ensure timely access to and receipt of needed physical and behavioral health services; supporting the individual's informed choice regarding services and supports they receive, providers who offer such services, and the setting in which services and supports are received which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS; specific documentation of any modifications to HCBS settings requirements based on the needs of the individual and in accordance with processes prescribed in federal and state regulation and protocol; and monitoring implementation of the ISP and initiating updates as needed and addressing concerns which may include reporting to management level staff within the provider agency; or reporting to DIDD when resolution is not achieved and the ISP is not being implemented. The ISC will provide the individual with information about self-advocacy groups and self-determination opportunities and assist in securing needed transportation supports for these opportunities when specified in the ISP or upon request of the individual.

Ongoing monitoring by the ISC is accomplished through a stratified approach, based on level of support need, as follows: A person assessed to have level of need 1, 2, or 3 for purposes of reimbursement or not receiving any residential or day service reimbursed based on level of need requires a minimum of at least one monthly in-person or telephone contact and at least one bi-monthly (every other month) face-to-face contact; at least one visit per quarter shall be conducted in the person's home. A person assessed to have level of need 4, 5, or 6 for purposes of reimbursement requires a minimum of at least one monthly face-to-face contact across all environments and in the person's residence at least quarterly. Each contact, whether in person or by phone, requires the ISC to complete and document a Monthly Status Review of the ISP for that person per service received across service settings. ~~Monitoring by ISCs is accomplished through completing a minimum of one face-to-face visit at least once quarterly and by completing a Monthly Status Review of the ISP. Persons enrolled in this waiver shall be contacted by their ISC at least monthly either in person or by telephone (i.e., the member's ISC must complete each subsequent contact in person or by telephone within thirty (30) calendar days of the previous in-person or telephone contact). These individuals shall be visited face-to-face by their ISC at least quarterly (i.e., within ninety (90) calendar days of the previous face-to-face visit).~~ Generally, face-to-face visits should be coordinated with the person supported (and

their family, as applicable) to occur in the person's residence. However, for persons not receiving residential services, if requested by the person (or their family, as applicable), visits can be scheduled at alternative locations that are convenient for the person and their family, unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted in the home.

Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request, or ~~which shall be documented in the ISP, or~~ based on a significant change in needs or circumstances. ~~The frequency of monitoring visits shall be specified in the ISP and may be provided more frequently as needed.~~ Information is gathered using standardized processes and tools.

The Support Coordination provider shall initiate and oversee at least annual reassessment of the individual's level of care eligibility, and initial and at least annual assessment of the individual's experience to confirm that that the setting in which the individual is receiving services and supports comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

Proposed Changes Applicable Only to the Self-Determination Waiver

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☑ **The participant is referred to another waiver that can accommodate the individual's needs.**

☑ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Under the Self-Determination Waiver Program, each participant has an individual budget based on an assessment of the participant's need for the services available in the program.

If a participant's budget reaches $30,000 and emergency assistance is needed, an exception to the cost limit of $30,000 may be granted to provide up to an additional $6,0000 in covered waiver services to provide an extra measure of protection when the participant experiences a crisis or emergency situation that threatens his/her health and well-being.

The total of all waiver services shall not exceed $36,000 per year per participant, provided however, that a waiver participant shall not be required to experience a reduction in the amount of services currently being provided as a result of any increase in the rate of payment for such services, including rate increases targeted to increase wages for direct support professionals in order to help providers recruit and retain staff. If an increase in the rate of payment for service(s) would result in a person's cost limit being exceeded, the person shall not be required to reduce the amount of previously authorized services. All new or additional services will be subject to the $30,000 cost limit (or $36,000 cost limit when emergency services are authorized) as specified in this waiver.

Except as provided above with regard to services a person is currently receiving for which the rate of payment is increased, if the cost for all waiver services, including additional services authorized Emergency Assistance services, reaches or is projected to reach the absolute waiver limit of $36,000 per year per participant and the participant's health and welfare cannot be ensured after seeking funding through non-waiver resources, the participant will be given an opportunity to request services through the Employment and Community First CHOICES program for which the participant may be eligible or, as appropriate, will be assisted in seeking admission to an ICF/IID.

If the condition or circumstances of a person enrolled in the waiver should change that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, and the person is not willing or able to enroll in a different program where his needs could be safely met, DIDD must submit to TennCare in writing an involuntary disenrollment request. Upon review and approval by TennCare, DIDD shall issue advance notice of involuntary disenrollment, including the right to request a fair hearing within 30 days. Fair hearings regarding involuntary termination of enrollment into an HCBS waiver are conducted in accordance with the Uniform Administrative Procedures Act. If an appeal is filed prior to the effective date of the action, continuation of waiver enrollment and waiver services are provided pending resolution of the appeal. In addition, if the person is disenrolled, DIDD shall provide reasonable assistance in locating appropriate alternative placement. However, a person enrolled in this waiver shall not be dis-enrolled if the sole reason the cost~~-.cap would be exceeded is a change in the reimbursement methodology that is required under the terms of the~~

~~Statewide Transition Plan described in Attachment 2A. of this waiver in order to achieve compliance with the federal HCBS Settings Rule.~~ limit would be exceeded is a change in the reimbursement methodology for employment and day services implemented under the terms of the completed Statewide Transition Plan for this waiver in order to achieve compliance with the federal HCBS Settings Rule. Persons supported shall be permitted to exceed the cost limit in order to continue receiving the same type and amount of services before the reimbursement change went into effect. In addition, to ensure compliance with the Rule, a person may be permitted to exceed the cost limit when additional Supported Employment- Individual Supports are requested and utilized.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

DIDD Case Managers assist persons supported in identifying their needs and preferences and selecting, obtaining and coordinating services using paid and natural supports. The Case Manager, in collaboration with the person supported, the person supported's authorized representative (if applicable), other persons specified by the person supported (this may include family members, friends, and paid service providers selected by the person) convene at time and location convenient to the person supported, in a formal Planning Meeting to discuss and finalize the ISP which is the person-centered ISP.

Each person-centered planning process must:

a. Be directed by the individual to the greatest extent possible,

b. Identify strengths and needs, both clinical and support needs, and desired outcomes,

c. Reflect cultural considerations and use language understandable by the individual,

d. Include strategies for solving disagreements,

e. Provide method for individual to request updates to be made to their ISP.

The policy and procedures which define and guide the person-centered planning process and assure that people chosen by the individual supported are integrally involved in the development of an ISP that reflects their preferences, choices, and desired outcomes provide for:

a. An assessment of the individual's status, adaptive functioning, and service needs through the administration of a uniform assessment instrument (such as the Supports Intensity Scale);

b. The identification of individual risk factors through the administration of a uniform risk assessment~~the Risk Issues Identification Tool, and,~~ identification of person-centered strategies to mitigate risks, and clear communication with the person supported and/or his/her representative, as applicable, regarding potential risks and ways to mitigate risks, to support an informed decision regarding whether the risk, as mitigated, is tolerable, including documentation of the ~~individual's~~ person's decision ~~understanding of the risks and mitigation strategies, including documentation~~ in the ISP ~~that those strategies have been clearly explained;~~

c. Additional assessments, where appropriate, by health care professionals (e.g., occupational or physical therapists, behavior analysts, etc.);

d. The identification of personal outcomes, support goals, supports and services needed, information about the person's current situation, what is important to the person supported, and changes desired in the person's life (e.g., home, work, relationships, community membership, health and wellness). (Information for the ISP will be gathered and developed through the person-centered planning process driven, to the greatest extent possible, by the person supported and, if applicable, in collaboration with the guardian or conservator, as well as family members and other persons specified by the person supported.);

e. Initial and at least annual assessment of the individual's experience to confirm that the setting in which the individual is receiving services and supports comports with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, except as supported by the individual's specific assessed need and set forth in the person-centered ISP; and

f. Waiver and other services are coordinated by the DIDD Case Manager through the development and implementation of the ISP. The ISP describes all the supports and services necessary to support the person to achieve their desired outcomes and attain or maintain a quality life as defined by them, including services that may be provided through natural supports, the Medicaid State Plan or pursuant to the person's Individual Education Plan (IEP).

The ISP development process includes the following: identification of personal outcomes, support goals, supports and services needed, information about the individual's current situation,

what is important to the individual, and changes desired in the person's life (e.g., home, work, relationships, community membership, health and wellness), supporting the individual's informed choice regarding services and supports they receive, providers of such services, and the setting in which services and supports are received and which shall be integrated in, and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS; and specific documentation of any modifications to HCBS settings requirements based on the needs of the individual and in accordance with processes prescribed in federal and state regulation and protocol. As required pursuant to the federal Person Centered Planning Rule, the ISP shall be signed by the individual and all persons involved in implementing the plan, including those providing paid and or unpaid supports.

The ISP is the fundamental tool by which the state ensures the health and welfare of the individuals served under this waiver. As such, it is subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the person's disability and are responsive to the person's needs and preferences. Persons enrolled in this waiver shall be contacted by their DIDD Case Manager at least monthly either in person or by telephone ~~(i.e., the member's Case Manager must complete each subsequent contact in person or by telephone within thirty (30) calendar days of the previous in-person or telephone contact)~~. These individuals shall be visited face-to-face by their DIDD Case Manager at least quarterly ~~(i.e., within ninety (90) calendar days of the previous face-to-face visit)~~. Face-to-face visits should be coordinated with the person supported (and their family, as applicable) and should generally occur in the person's residence. However, for persons not receiving residential services, if requested by the person (or their family, as applicable), visits can be scheduled at alternative locations that are convenient for the person and their family, unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted in the home. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request, or ~~which shall be documented in the ISP, or~~ based on a significant change in needs or circumstances. Completion of a monthly status review of the ISP will be documented for each individual per service received and across service settings.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare;

(b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

DIDD Case Managers assist persons supported in identifying needs and preferences, and in selecting, obtaining, and coordinating services using paid and natural supports. Ongoing monitoring by Case Managers is essential and they are responsible for determining if services are being implemented as specified in the ISP and if the services described in the plan are meeting the person's needs.

Ongoing monitoring by the DIDD Case manager is accomplished through contacts and face-to-face monitoring visits.

Persons enrolled in this waiver shall be contacted by their DIDD Case Manager at least monthly either in person or by telephone ~~(i.e., the member's Case Manager must complete each subsequent contact in person or by telephone within thirty (30) calendar days of the previous in-person or telephone contact)~~. These individuals shall be visited face-to-face by their DIDD Case Manager at least quarterly ~~(i.e., within ninety (90) calendar days of the previous face-to-face visit)~~. Face-to-face visits should be coordinated with the person supported (and their family, as applicable) and should generally occur in the person's residence. However, if requested by the person (or their family, as applicable), visits can be scheduled at alternative locations that are convenient for the person and their family, unless there are specific concerns regarding the person's health and safety which would warrant that the visit is conducted in the home. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the person's needs and/or request ~~which shall be documented in the ISP, ,~~or based on a significant change in needs or circumstances. Completion of a monthly status review of the ISP will be documented for each individual per service received and across service settings.

Information is gathered using standardized processes and tools. The Case Manager reports issues identified to management staff from the appropriate provider agencies. DIDD Regional Office management staff may assist in achieving resolution when timely provider response does not occur.

All individuals who receive supports and services through DIDD are required to have an annual risk assessment. This assessment is a component of the planning process intended to identify potential risks and create an environment that establishes appropriate safeguards without limiting personal experiences. Risk management is accomplished through risk assessment and identification of risk factors, risk analysis and planning, ongoing evaluation of the effectiveness of risk management strategies, and staff training and re-training as appropriate.

The success of individual strategies to ameliorate individual risks identified through risk assessment are evaluated by the person supported, their families and significant others, providers, and the Case Manager as part of on-going planning for and monitoring of services.

In addition, the Case Manager conducts initial (i.e., as part of the State's initial assessment of compliance with the new federal HCBS Setting rule) and at least annual assessment of the individual's experience, in accordance with timeframes outlined in State Protocol, to confirm

that that the setting in which the person supported is receiving services and supports comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, including those requirements applicable to provider-owned or controlled homes, except as supported by the individual's specific assessed need and set forth in the person-centered ISP.

Proposed Changes Applicable Only to the Statewide Waiver

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☑ **Other safeguard(s)**

Specify:

Should a change in the participant's condition or circumstances post-entrance to the waiver require the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, TennCare and DIDD will first work with the Independent Support Coordinator and with the participant's MCO to determine whether additional services and supports needs can be met through covered or cost-effective alternative services available through the managed care program~~,~~, or through the use of assistive technology, allowing the person to continue participation in the waiver program. If, following such coordination efforts, it is determined that the participant's health and welfare cannot be assured in the waiver, TennCare and DIDD will work with the individual to facilitate transition to another more appropriate LTSS program or service. This includes the Managed Long Term Services and Supports Program, Employment and Community First CHOICES.

Notice of disenrollment, including the right to fair hearing, would be issued. The applicant would have 30 days to request a fair hearing from TennCare. Fair hearings regarding disenrollment from an HCBS waiver are conducted in accordance with the Uniform Administrative Procedures Act. However, a person enrolled in this waiver shall not be dis-enrolled if the sole reason the individual cost limit ~~cap~~ would be exceeded is a change in the reimbursement methodology for employment and day services implemented ~~that is required~~ under the terms of the completed Statewide Transition Plan ~~described in Attachment 2. of this waiver~~ for this waiver in order to achieve compliance with the federal HCBS Settings Rule. Persons supported shall be permitted to exceed the cost limit in order to continue receiving the same type and amount of services before the reimbursement change went into effect. In addition, to ensure compliance with the Rule, a person may be permitted to exceed the individual cost limit when additional Supported Employment-Individual Supports are requested and utilized. A waiver participant shall not be disenrolled or required to experience a reduction in the amount of services currently being provided as a result of State increases in the rate of payment for such services, including rate increases targeted to increase wages for direct support professionals in order to help providers recruit and retain staff. If an increase in the rate of payment for service(s) would result in a person's cost limit being exceeded, the person shall not be required to reduce the amount of previously authorized services. The State may establish a methodology that would disregard some or all such rate increases in the application of the individual cost limit. Except as provided in that methodology, all new or additional services will be subject to the individual cost limit as specified in this waiver.